

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G229 6-5-58 at

6307

CERTIFICATE OF DEATH

06298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural</u>	
c. LENGTH OF STAY IN 1b <u>10 years</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hector</u> Middle <u>Black</u> Last <u>shears</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 4 yrs.</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>260-24-4235</u>	
17. INFORMANT <u>Unknown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease.</u> DUE TO (c) <u>Chronic bronchial asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1 1/2 yrs</u> <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-17, 1956</u> to <u>May 26, 1958</u> , that I last saw the deceased alive on <u>May 26, 1958</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ivory U. Seelye, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Seelye, Jr.</u>		DATE SIGNED <u>4/28/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 2, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Potter Field</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Morris</u> ADDRESS <u>Snow Hill Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Seelye</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

63'8

## CERTIFICATE OF DEATH

Reg. Dist. No. 06299

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shuttleworth</u>		c. LENGTH OF STAY IN 1b <u>62 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shuttleworth</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Sallie</u> Middle <u>L.</u> Last <u>Dukes</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21-1862</u>
9. AGE (In years, last birthday) <u>96 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Shuttleworth, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John H. Truitt</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Rowley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Mary C. Dukes, Shuttleworth, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x</u> <u>Cachexia + Emaciation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>atherosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> to <u>May 14, 1958</u> , that I last saw the deceased alive on <u>May 13, 1958</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St., Snow Hill, Md</u> DATE SIGNED <u>5-14-58</u>			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		104 Bay St., Snow Hill, Md 5-14-58	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>May 14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Whatcoat Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Thomas</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Thomas</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John J. Sullivan</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15, 1880</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>Jan 1, 1905</i></p>	
<p>9. NAME OF SPOUSE <i>Elizabeth J. Sullivan</i></p>		<p>10. DATE OF DEATH <i>Jan 10, 1925</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. J. Sullivan</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John J. Sullivan</i></p>		<p>16. SIGNATURE OF DECEASED <i>John J. Sullivan</i></p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

6309

CERTIFICATE OF DEATH

Reg. Dist. No. 06300

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishop</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishop</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>RTD</i>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>ESSEL MAY GAULT</i>				4. DATE OF DEATH Month Day Year <i>May 12 1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 6, 1894</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Frank Campbell</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Bailey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes, give war or dates of service				17. INFORMANT Address <i>James E. Gault Bishop Ind.</i>			
16. SOCIAL SECURITY NO. <i>442X</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C. V. A. Recurrent.</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i> DUE TO <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>260X</i> (b) <i>Cerebral Arteriosclerosis</i> <i>7-8 mo</i> (c) <i>Generalized Arteriosclerosis - C.V. R.</i> <i>10 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <i>Diabetes Mellitus</i> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>June 1947</i> , to <i>12 May 1958</i> , that I last saw the deceased alive on <i>11 May 1958</i> , and that death occurred at <i>2:30 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Herman A. Robbins</i> M.D.				ADDRESS (Street, city or town, state) <i>Bishop, Ind.</i> DATE SIGNED <i>5/12/58</i>			
PHYSICIAN'S NAME (Type) <i>HERMAN A. ROBBINS, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/15/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>L.O.F.</i>		22d. LOCATION (City, town, or county) (State) <i>Bishopville, Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edith Whaley Schuyler</i> ADDRESS <i>Bishopville, Ind.</i>				24a. REC'D BY REGISTRAR <i>May 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Albrecht</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6310

## CERTIFICATE OF DEATH

06301

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishop RFD</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishop</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <i>RFD</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Henry</i> Last <i>Godfrey</i>			4. DATE OF DEATH Month <i>May</i> Day <i>9</i> Year <i>1958</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 14, 1888</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>John H. Godfrey</i>			14. MOTHER'S MAIDEN NAME <i>Marie E. Shorn</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-1844311</i>		17. INFORMANT <i>Nette Godfrey Bishop, Md RFD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>May 3 - , 1958</i> , to <i>May 9 - , 1958</i> , that I last saw the deceased alive on <i>May 8 - , 1958</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Chas. R. Saw</i>			ADDRESS (Street, city or town, state) <i>Berlin Md</i> DATE SIGNED <i>May 10 - 1958</i>		
PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<i>Buried</i>		<i>5/12/58</i>		<i>Red Men</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
<i>Edwin W. Kelly</i>		<i>Seligsville, Md.</i>		DATE <i>MAY 13 '58</i>	
24b. REGISTRAR'S SIGNATURE					
<i>W. L. Beach</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6810

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>10/15/1925</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
MARRIAGE <i>Married</i>		DATE OF DEATH <i>11/10/1985</i>		PLACE OF DEATH <i>St. Louis, Mo.</i>	
SEX <i>Male</i>		RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
PREVIOUS ILLNESS <i>None</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
DATE OF LAST ILLNESS <i>11/5/1985</i>		DATE OF LAST PHYSICIAN VISIT <i>11/5/1985</i>		NAME OF PHYSICIAN <i>Dr. J. Smith</i>	
NAME OF FUNERAL HOME <i>None</i>		NAME OF BURIAL PLACE <i>None</i>		DATE OF BURIAL <i>None</i>	
NAME OF NEXT OF KIN <i>John Doe, Jr.</i>		ADDRESS OF NEXT OF KIN <i>123 Main St.</i>		CITY OF NEXT OF KIN <i>St. Louis, Mo.</i>	
STATE OF NEXT OF KIN <i>Mo.</i>		ZIP CODE OF NEXT OF KIN <i>63101</i>		TELEPHONE OF NEXT OF KIN <i>None</i>	
SIGNATURE OF DECEASED <i>None</i>		SIGNATURE OF NEXT OF KIN <i>John Doe, Jr.</i>		DATE OF SIGNATURE <i>11/10/1985</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		DATE OF SIGNATURE <i>11/10/1985</i>		PLACE OF SIGNATURE <i>St. Louis, Mo.</i>	

TO BE FILLED BY THE REGISTRAR  
1. NAME OF DECEASED  
2. DATE OF DEATH  
3. PLACE OF DEATH  
4. CAUSE OF DEATH  
5. MANNER OF DEATH  
6. NAME OF PHYSICIAN  
7. NAME OF FUNERAL HOME  
8. NAME OF BURIAL PLACE  
9. DATE OF BURIAL  
10. NAME OF NEXT OF KIN  
11. ADDRESS OF NEXT OF KIN  
12. CITY OF NEXT OF KIN  
13. STATE OF NEXT OF KIN  
14. ZIP CODE OF NEXT OF KIN  
15. TELEPHONE OF NEXT OF KIN



6311

## CERTIFICATE OF DEATH

06302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (When deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Martins</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edward</i> First <i>H.</i> Middle <i>H.</i> Last <i>Hall</i>		4. DATE OF DEATH <i>May 24 1958</i> Month <i>May</i> Day <i>24</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 24, 1904</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Orchard</i>	9. AGE (In years lost birthday) <i>53</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Hall</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-16-2250</i>	17. INFORMANT <i>Doris Hall</i> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broken Neck &amp; fractured Skull</i> 322.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>A fall down high flight of steps</i> DUE TO (c) <i>Alcoholic intoxication</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Alcoholic</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tripped at top of flight of steps and fell to ground</i>	
20c. TIME OF INJURY Month, Day, Year <i>May 24 1958</i> Hour <i>9:45</i> o. m. p. m.	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 24th</i> to <i>May 24th</i> , 1958, that I last saw the deceased alive on <i>May 24th</i> , 1958, and that death occurred at <i>9:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>N.E. Sartorius</i> M.D.		DATE SIGNED <i>Pocomoke City, Md.</i>	
PHYSICIAN'S NAME (Type) <i>N.E. Sartorius</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>May 27, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Riley</i>	22d. LOCATION (City, town, or county) (State) <i>Whaleyville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter Whaley Selbyville, Del.</i>		24a. REC'D BY REGISTRAR <i>May 29 '58</i> DATE	24b. REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page Two

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>10/15/1925</i></p>		<p>4. Place of birth: <i>St. Louis, Mo.</i></p>	
<p>5. Date of death: <i>11/10/1985</i></p>		<p>6. Place of death: <i>Home</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Date of registration: <i>11/15/1985</i></p>		<p>12. Place of registration: <i>Baltimore</i></p>	
<p>13. Name of informant: <i>John Doe</i></p>		<p>14. Address of informant: <i>123 Main St.</i></p>	
<p>15. Telephone number: <i>555-1234</i></p>		<p>16. Signature of informant: <i>[Signature]</i></p>	
<p>17. Date of completion: <i>11/15/1985</i></p>		<p>18. Signature of official: <i>[Signature]</i></p>	
<p>19. Date of filing: <i>11/15/1985</i></p>		<p>20. Signature of official: <i>[Signature]</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detailed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6312

## CERTIFICATE OF DEATH

06303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 3</u>				d. STREET ADDRESS <u>Route # 3</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MAHIE</u> Middle <u>E</u> Last <u>HENRY</u>				4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>F.M.</u>	6. COLOR OR RACE <u>A.R.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY HENRY</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN THASSEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-4524</u>		17. INFORMANT Address <u>Mrs. Roger Gunby, Berlin, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic coma</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/2</u> 19 <u>54</u> to <u>5/19</u> 19 <u>58</u> , that I last saw the deceased alive on <u>5/19</u> 19 <u>58</u> , and that death occurred at <u>2:00 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>5/22/58</u>			
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.F. Stewart Funeral Home, Salisbury, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

CERTIFICATE OF DEATH

Age last Jan

PLACED IN

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

NO. OF DEATH  
REGISTERED

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

6313

## CERTIFICATE OF DEATH

Reg. Dist. No.

06305

1. PLACE OF DEATH o. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				c. LENGTH OF STAY IN 1b <b>82 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AMELIA</b> Middle <b>JANE</b> Last <b>MASSEY</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 9, 1873</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN RFD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JAMES GRAY</b>				14. MOTHER'S MAIDEN NAME <b>LAURA Richardson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mrs. MILTON HASTINGS BERLIN, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia and Uremic Coma</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Metastatic Ca.</b> DUE TO (c) <b>Intestinal Carcinomatosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1-2 years</b> <b>4-5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan. 1954</b> to <b>May 1958</b> , that I last saw the deceased alive on <b>May 4, 1958</b> , and that death occurred at <b>8:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5 BAY ST., BERLIN, Md.</b> DATE SIGNED <b>5/5/58</b>							
ACTUAL SIGNATURE <b>Robert A. Grubb, M.D.</b>				PHYSICIAN'S NAME (Type) <b>ROBERT A. GRUBB, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna B. Burbage</b>				ADDRESS <b>Berlin Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 9 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Deborah</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6314 CERTIFICATE OF DEATH

06306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snnow Hill- Rural</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 7mons.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Public Landing</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ann a</b> <b>Stowell</b> <b>Prouse</b>				4. DATE OF DEATH <b>May</b> <b>12</b> <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1874</b>	9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry F. Stowell</b>				14. MOTHER'S MAIDEN NAME <b>Annie Herr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-3241</b>		17. INFORMANT Address <b>Mrs. J. Hazelwood Spicer, Snow Hill, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 yrs</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>no ne</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 15, 1957</b> to <b>May 12, 1958</b> , that I last saw the deceased alive on <b>May 8, 1958</b> , and that death occurred at <b>11:30p M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert C. La Mar</b>				ADDRESS (Street, city or town, state) <b>106 Bay St, Snow Hill, Md.</b>		DATE SIGNED <b>5/13/58</b>	
PHYSICIAN'S NAME (Type) <b>Robert C. La Mar, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Framptom &amp; Son, Federalburg, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. NO. 100

1. NAME OF DECEASED ROBERT J. BART, JR.		2. SEX Male		3. AGE 37		4. DATE OF BIRTH 1900	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. EDUCATION High School	
9. CAUSE OF DEATH Coronary Arteriosclerosis		10. MANNER OF DEATH Natural		11. PLACE OF DEATH Home		12. TIME OF DEATH 10:30 AM	
13. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		14. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		15. SIGNATURE OF WITNESSES J. H. Smith, M.D.		16. SIGNATURE OF DECEASED J. H. Smith, M.D.	
17. SIGNATURE OF DECEASED J. H. Smith, M.D.		18. SIGNATURE OF DECEASED J. H. Smith, M.D.		19. SIGNATURE OF DECEASED J. H. Smith, M.D.		20. SIGNATURE OF DECEASED J. H. Smith, M.D.	
21. SIGNATURE OF DECEASED J. H. Smith, M.D.		22. SIGNATURE OF DECEASED J. H. Smith, M.D.		23. SIGNATURE OF DECEASED J. H. Smith, M.D.		24. SIGNATURE OF DECEASED J. H. Smith, M.D.	
25. SIGNATURE OF DECEASED J. H. Smith, M.D.		26. SIGNATURE OF DECEASED J. H. Smith, M.D.		27. SIGNATURE OF DECEASED J. H. Smith, M.D.		28. SIGNATURE OF DECEASED J. H. Smith, M.D.	
29. SIGNATURE OF DECEASED J. H. Smith, M.D.		30. SIGNATURE OF DECEASED J. H. Smith, M.D.		31. SIGNATURE OF DECEASED J. H. Smith, M.D.		32. SIGNATURE OF DECEASED J. H. Smith, M.D.	
33. SIGNATURE OF DECEASED J. H. Smith, M.D.		34. SIGNATURE OF DECEASED J. H. Smith, M.D.		35. SIGNATURE OF DECEASED J. H. Smith, M.D.		36. SIGNATURE OF DECEASED J. H. Smith, M.D.	
37. SIGNATURE OF DECEASED J. H. Smith, M.D.		38. SIGNATURE OF DECEASED J. H. Smith, M.D.		39. SIGNATURE OF DECEASED J. H. Smith, M.D.		40. SIGNATURE OF DECEASED J. H. Smith, M.D.	
41. SIGNATURE OF DECEASED J. H. Smith, M.D.		42. SIGNATURE OF DECEASED J. H. Smith, M.D.		43. SIGNATURE OF DECEASED J. H. Smith, M.D.		44. SIGNATURE OF DECEASED J. H. Smith, M.D.	
45. SIGNATURE OF DECEASED J. H. Smith, M.D.		46. SIGNATURE OF DECEASED J. H. Smith, M.D.		47. SIGNATURE OF DECEASED J. H. Smith, M.D.		48. SIGNATURE OF DECEASED J. H. Smith, M.D.	
49. SIGNATURE OF DECEASED J. H. Smith, M.D.		50. SIGNATURE OF DECEASED J. H. Smith, M.D.		51. SIGNATURE OF DECEASED J. H. Smith, M.D.		52. SIGNATURE OF DECEASED J. H. Smith, M.D.	
53. SIGNATURE OF DECEASED J. H. Smith, M.D.		54. SIGNATURE OF DECEASED J. H. Smith, M.D.		55. SIGNATURE OF DECEASED J. H. Smith, M.D.		56. SIGNATURE OF DECEASED J. H. Smith, M.D.	
57. SIGNATURE OF DECEASED J. H. Smith, M.D.		58. SIGNATURE OF DECEASED J. H. Smith, M.D.		59. SIGNATURE OF DECEASED J. H. Smith, M.D.		60. SIGNATURE OF DECEASED J. H. Smith, M.D.	
61. SIGNATURE OF DECEASED J. H. Smith, M.D.		62. SIGNATURE OF DECEASED J. H. Smith, M.D.		63. SIGNATURE OF DECEASED J. H. Smith, M.D.		64. SIGNATURE OF DECEASED J. H. Smith, M.D.	
65. SIGNATURE OF DECEASED J. H. Smith, M.D.		66. SIGNATURE OF DECEASED J. H. Smith, M.D.		67. SIGNATURE OF DECEASED J. H. Smith, M.D.		68. SIGNATURE OF DECEASED J. H. Smith, M.D.	
69. SIGNATURE OF DECEASED J. H. Smith, M.D.		70. SIGNATURE OF DECEASED J. H. Smith, M.D.		71. SIGNATURE OF DECEASED J. H. Smith, M.D.		72. SIGNATURE OF DECEASED J. H. Smith, M.D.	
73. SIGNATURE OF DECEASED J. H. Smith, M.D.		74. SIGNATURE OF DECEASED J. H. Smith, M.D.		75. SIGNATURE OF DECEASED J. H. Smith, M.D.		76. SIGNATURE OF DECEASED J. H. Smith, M.D.	
77. SIGNATURE OF DECEASED J. H. Smith, M.D.		78. SIGNATURE OF DECEASED J. H. Smith, M.D.		79. SIGNATURE OF DECEASED J. H. Smith, M.D.		80. SIGNATURE OF DECEASED J. H. Smith, M.D.	
81. SIGNATURE OF DECEASED J. H. Smith, M.D.		82. SIGNATURE OF DECEASED J. H. Smith, M.D.		83. SIGNATURE OF DECEASED J. H. Smith, M.D.		84. SIGNATURE OF DECEASED J. H. Smith, M.D.	
85. SIGNATURE OF DECEASED J. H. Smith, M.D.		86. SIGNATURE OF DECEASED J. H. Smith, M.D.		87. SIGNATURE OF DECEASED J. H. Smith, M.D.		88. SIGNATURE OF DECEASED J. H. Smith, M.D.	
89. SIGNATURE OF DECEASED J. H. Smith, M.D.		90. SIGNATURE OF DECEASED J. H. Smith, M.D.		91. SIGNATURE OF DECEASED J. H. Smith, M.D.		92. SIGNATURE OF DECEASED J. H. Smith, M.D.	
93. SIGNATURE OF DECEASED J. H. Smith, M.D.		94. SIGNATURE OF DECEASED J. H. Smith, M.D.		95. SIGNATURE OF DECEASED J. H. Smith, M.D.		96. SIGNATURE OF DECEASED J. H. Smith, M.D.	
97. SIGNATURE OF DECEASED J. H. Smith, M.D.		98. SIGNATURE OF DECEASED J. H. Smith, M.D.		99. SIGNATURE OF DECEASED J. H. Smith, M.D.		100. SIGNATURE OF DECEASED J. H. Smith, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH**

Reg. Dist. No.

06307

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				c. LENGTH OF STAY IN 1b <b>20 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JONES WILLIAM RICHARDSON</b>				4. DATE OF DEATH Month Day Year <b>MAY 29, 1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 3, 1884</b>		9. AGE (In years last birthday) <b>74</b>	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAPTAIN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT MARINES</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES E. RICHARDSON</b>				14. MOTHER'S MAIDEN NAME <b>EMMA DINGEE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>62-13-5576</b>		17. INFORMANT <b>MR. FRED RICHARDSON</b>		Address <b>BERLIN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Bright's</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2. yes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan</b> , 1958, to <b>May 29</b> , 1958, that I last saw the deceased alive on <b>May 28</b> , 1958, and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Berlin Md</b> DATE SIGNED <b>5-31-1958</b>							
ACTUAL SIGNATURE <b>Chas. R. Saw</b> M.D.				DATE SIGNED <b>5-31-1958</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/1/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage</b> ADDRESS <b>Berlin Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 3 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

CERTIFICATE OF DEATH

For This Use

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		PERIOD OF ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF OTHER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU ONE 18

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU ONE 18



6316

CERTIFICATE OF DEATH

Reg. Dist. No. 06308

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN RFD</b>		c. LENGTH OF STAY IN 1b <b>5 YEARS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN RFD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>Edgar</b> Last <b>Riggs</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>1958</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 22, 1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED JOCKEY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RACING</b>		11. BIRTHPLACE (State or foreign country) <b>HAMMONTON, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE Edgar Riggs</b>		14. MOTHER'S MAIDEN NAME <b>MARY ADLER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>157 16 9897</b>	
17. INFORMANT <b>Mrs. H. E. AHERN</b>		Address <b>242 Woodland Ave. Wyckoff, N.J.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) <b>myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive cardiac failure</b> 45 years DUE TO (c) <b>old myocardial infarction</b> 5 years INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov.</b> 19 <b>57</b> , to <b>May</b> 19 <b>58</b> , that I last saw the deceased alive on <b>May 6</b> 19 <b>58</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Berlin, Md.</b> DATE SIGNED <b>5-8-58</b> ACTUAL SIGNATURE <b>Robert A. Grubb, M.D.</b> PHYSICIAN'S NAME (Type) <b>ROBERT A. GRUBB, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna R. Barbage</b> ADDRESS <b>Berlin Md.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. SERVICE</p> <p>12. PLACE OF DEATH</p> <p>13. DATE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF REGISTRAR</p> <p>18. SIGNATURE OF PHYSICIAN</p> <p>19. SIGNATURE OF FUNERAL HOME</p> <p>20. SIGNATURE OF WITNESSES</p>		<p>21. NAME OF REGISTRAR</p> <p>22. NAME OF PHYSICIAN</p> <p>23. NAME OF FUNERAL HOME</p> <p>24. NAME OF WITNESSES</p>
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6317

## CERTIFICATE OF DEATH

Reg. Dist. No.

06309

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirddetee</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirddetee</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>L.</u> Last <u>Rowley</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20 - 1861</u>	
9. AGE (In years, last birthday) <u>96 3/4</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>		11. BIRTHPLACE (State or foreign country) <u>Shirddetee, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jesse Jones</u>				14. MOTHER'S MAIDEN NAME <u>Sallie A. Rowley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Fatherine Rowley Webb, Shirddetee, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA AND INANITION</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE WITH UREMIA (3 WKS)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>AUGUST</u> , 19 <u>50</u> , to <u>MAY 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAY 7</u> , 19 <u>58</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. Lamar</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Bay Street</u>			
PHYSICIAN'S NAME (Type) <u>Robert C. Lamar, M.D.</u>				DATE SIGNED <u>5-7-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Snow Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shirddetee, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May C. Dennis</u> ADDRESS <u>Snow Hill, MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Deane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6318 CERTIFICATE OF DEATH

Reg. Dist. No. 06310

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>8 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route # 3</u>				d. STREET ADDRESS <u>Route # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Shirley T. Sample</u>				4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Wic.</u> <u>SEPT. 9, 1957</u>		9. AGE (In years last birthday) yrs. <u>8</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>22</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HAROLD SAMPLE</u>				14. MOTHER'S MAIDEN NAME <u>Emma Louise B. Hingham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>THR. Harold Sample, Berlin, Md. Rt #3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/31</u> , 19 <u>58</u> , to <u>5/31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/31</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>		DATE SIGNED <u>6/1/58</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L.F. Stewart</u>				ADDRESS <u>FUNERAL HOME, SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082377XV5



CERTIFICATE OF DEATH

Page 504-11

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		65		1878		BALTIMORE, MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
LABORER		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JAN 15 1945		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		12345	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		PLACE		CAUSE		MANNER		CERTIFICATE NO.	
JAN 15 1945		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		12345	

This is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on January 15, 1945.

THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON JANUARY 15, 1945.

## 6319 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY RFD</b>		c. LENGTH OF STAY IN 1b <b>78 YRS.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WORCESTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY RFD</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>OSCAR Timmons</b>						4. DATE OF DEATH Month Day Year <b>MAY 10 1958</b>									
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 22, 1880</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>				11. BIRTHPLACE (State or foreign country) <b>BERLIN, MD. RFD</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William J. Timmons</b>						14. MOTHER'S MAIDEN NAME <b>MARY BELLE Smack</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs. OSCAR Timmons</b>		Address <b>OCEAN CITY, MD</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interosclerotic C-V renal disease</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Esophageal diverticulum, Bicuspid Aortic Regurgitation</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Berlin</b>		(County) <b>Maryland</b>		(State) <b>Maryland</b>			
21. I certify that I attended the deceased from <b>April 15, 1958</b> , to <b>May 10, 1958</b> , that I last saw the deceased alive on <b>May 10, 1958</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Berlin, Maryland</b> DATE SIGNED <b>May 14, 1958</b>															
ACTUAL SIGNATURE <b>N. P. Thomas</b>				M.D. <b>N. P. Thomas</b>				DATE SIGNED <b>May 14, 1958</b>							
PHYSICIAN'S NAME (Type) <b>N. P. Thomas</b>				ADDRESS <b>Berlin, Maryland</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>MAY 14, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BUCKINGHAM</b>				22d. LOCATION (City, town, or county) (State) <b>BERLIN Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Karlase Funeral Home</b>						ADDRESS <b>Berlin</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Beach</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/SS

